

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS2838HIC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2009
NAME OF PROVIDER OR SUPPLIER WASHINGTON SENIOR GUEST HOME 1		STREET ADDRESS, CITY, STATE, ZIP CODE 1817 SPRING SUMMIT LN LAS VEGAS, NV 89134		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	<p>Initial Comments</p> <p>Surveyor: 28264</p> <p>This Statement of Deficiencies was generated as a result of a State licensure survey conducted in your facility on 11/4/09. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The census at the time of the survey was zero. Zero resident files were reviewed and two employee files were reviewed.</p> <p>The following regulatory deficiencies were identified:</p>	H 000		
H 019	<p>Director Duties-No FA/CPR</p> <p>NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present.</p> <p>This Regulation is not met as evidenced by: Surveyor: 28264</p>	H 019		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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H 019	Continued From page 1 Based on record review and staff interview on 11/4/09, the director did not ensure that 2 of 2 caregivers had received training in cardiopulmonary resuscitation (CPR) and first aid (Employee #1, and #2)	H 019			

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